

ABSTRACT
SOCIAL WORK

Thomas, Mary Louise

B.A. LANE COLLEGE, 1971

AN EXPLORATORY DESCRIPTIVE STUDY OF WOMEN AT RISK FOR
HIV/AIDS: DIAGNOSED HIV POSITIVE AND NON-DIAGNOSED.

Advisor: Professor, Hattie Mitchell

Thesis Dated: May, 1991

The overall objective of this study was to examine the attitudes and self-esteem of Women At Risk for HIV/AIDS: Diagnosed and Non-Diagnosed. To obtain this objective, attitudes and self-esteem were addressed by the researcher. A comparative research design was used in this study. A self-administered questionnaire was distributed to diagnosed and non-diagnosed women.

The study was an attempt to provide a better understanding of how the attitudes and self-esteem is impacted by an HIV/AIDS diagnosis on Women At Risk. To achieve this objective, the researcher identified the following variables; stress, stigma, self-esteem, family relation and isolation in effort to determine

how social workers can better assist this segment of the HIV/AIDS population.

The findings of this research indicates that there was a significant difference between the attitudes and self-esteem of the diagnosed and non-diagnosed women.

AN EXPLORATORY DESCRIPTIVE STUDY OF WOMEN AT RISK FOR
HIV/AIDS: DIAGNOSED HIV POSITIVE AND NON-DIAGNOSED

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
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THE DEGREE OF MASTER OF SOCIAL WORK

BY

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CHAPTER ONE

INTRODUCTION

When the HIV/AIDS virus was first recognized in (1981), it was thought to be a gay white male disease by the general public, as well as professional social workers. As time passed, we learned that the disease was not exclusive to the homosexual white population. The disease has impacted the total human family-men, women, children, homosexual, bisexuals, and IV drug users. Center for Disease Control (1990) projected that by the end of 1993 there will be between 390,000 and 480,000 diagnosed AIDS cases in the United States.

The evidence is clear that the HIV/AIDS virus continues to spread. During the past decade and increasing number of women have been affected by the HIV/AIDS infection. African American women in their child bearing years account for 52 percent of all women with AIDS (Center for Disease Control 1986). The African American population is disproportionately impacted by HIV/AIDS. Center for Disease Control (1990) noted that only 12 percent of the United States population is composed of Blacks, yet Blacks constitute 27 percent of all HIV/AIDS cases.

Women are now the fastest growing group of people with AIDS in the United States. Among women diagnosed with AIDS, more than 53 percent used injectable drugs, another 20 percent have male partners who inject drugs, NOVA Research-NOVA, (1990). HIV/AIDS affect the poor and lower socio-economic segment of society with a notable impact.

HIV disease is a social problem in that personal and societal values, attitudes, spiritual morals, and economic and political power structures lay the foundation for the nature and extent of response to the epidemic, (Stuntzner-Gibson, 1990). HIV-infected women in this Country are influenced by a range of factors: (a) poverty, (b) racism, (c) unemployment or low paying jobs, (d) lack of accessibility to proper medical care, (e) breakdown of family life, (f) hopelessness and ghetto lifestyles, (g) inadequate education preparation, (h) easy availability of drugs in the community. These factors create a great deal of conflict for women who are infected with HIV/AIDS. Additional complicating factors for the HIV infected women are unprotected sexual contact, stigma, stress, isolation and alienation.

The term AIDS was coined in 1982. Acquired Immune

Deficiency Syndrome is the manifestation of depletion of a person's immune functioning. AIDS is a complex disease. It is caused by a virus called the Human Immunodeficiency Virus (HIV). The most common means of transmission are; (1) semen and vaginal and cervical secretions, shared during sex (2) blood, contained in needles or other paraphernalia shared by intravenous drugs users, or transfusion with contaminated blood; (3) in utero transmission, from an HIV-positive mother to the fetus.

The child bearing women are the major source for infants who are born infected with the virus, Center for Disease Control (1988) notes that pediatrics AIDS' is not the typical "family" disease, it is a disease that largely affects families who are already seriously dysfunctional and disenfranchised. Nearly 60 percent of pediatric AIDS has been associated with IV drugs use either by the mother herself or by the father, who then infected the mother by sexual transmission. Although African American and Hispanic children represent 24 percent of children in this country, they account for 75 percent of children with AIDS in this country. It is critical for social workers to understand the dynamics of pediatric AIDS'.

A major concern for social workers with women at risk for HIV is that the medical community and researchers have failed to focus attention on women who are infected with the virus. Women who have been infected with the virus infection, have been in a limited number of trials studies and research, NIAIA (1990). Women are usually diagnosed later in the illness and the life expectancy is shorter than men who are infected with the virus.

According to Gutierrez, (1990) women of color experience the "double jeopardy" of racism and sexism in United States society. Kovel (1970) notes this view that since the earliest days of slavery, racist practices and ideology, extending beyond the individual behavior of white persons into the institutional structure and cultural mores of American, have had as their goal the dehumanization of Black people.

The Center for Disease Control (1984) definition for AIDS did not include many of the gynecological AIDS related infections that affect women. This resulted in a disadvantage for women in general, and the African American women in particular, to receive medicines, health care and also make them ineligible for financial entitlement that are available to males infected with

HIV. Gutierrez (1990) suggest that if social workers are to work effectively with women, and women of color, they need to address how the powerless position of these women in society contributes to individual client problems. This creates a challenge for the social worker. HIV/AIDS is one of the greatest social health crisis that social workers have had to confront. It is critical that social workers understand the impact of HIV on women.

Certainly because of already-existing discrimination against women, the HIV-positive African American women, whose psychosocial situation can be extremely complex, is likely to be severely undeserved.

The reluctance of the social work profession to initially "own" the HIV/AIDS crisis in women, and African American women specifically, to acknowledge the devastating toll it is making on the African American community, is perhaps the predictable outgrowth of racism and sexism. This research will examine some of the factors that remain unclear about Women at Risk for HIV/AIDS: diagnosed HIV positive and non-diagnosed. It will focus specifically on two factors: (1) self esteem and (2) attitudes.

Statement of the Problem

Stuntzner-Gibson (1991) notes that HIV disease is of major concern to social workers. HIV disease is a social problem in that personal and societal value, attitudes, spiritual, morals, and economics and political power structure lay the foundation for the nature and extent of response to this epidemic. In recent years, the high incidence of HIV/AIDS among women has been identified as a major social and health problem. Women are viewed as the fastest growing category of people with AIDS in America, yet this fact has been consistently ignored in the social work literature. It is timely that research on Women At Risk For HIV/AIDS: Diagnosed HIV Positive and Non-Diagnosed be explored. Center for Disease Control (CDC, 1988) reports that a greater percentage of African-Americans are becoming infected with HIV than are white in the United States. African-Americans with HIV/AIDS encounter diminishing physical and social resources, stigma, social isolation, psychological distress, serial opportunistic infections, and uncertainty as a way of life.

HIV/AIDS in women of color can not be dismissed as a disease that affect only those "others". It is a

disease of the powerless and the stigmatized in our society.

The HIV-positive women faces great hostility from both the public and professionals. If drugs use was involved and especially, if it is continuing, social work providers may be very critical, perceiving her as a neglectful mother who continues to jeopardize her children. However, little consideration is given to the gamut of psychosocial issues of drug dependence and shortage of drug-abuse treatment and other social services available to women, including pregnant women and mothers.

An especially crucial issue for women at risk, diagnosed HIV-positive and non-diagnosed are medical and civil right considerations. Is how HIV-related medical treatment differs for a pregnant women, compared to that for a non-pregnant women or a man. The fetus-versus-mother issue has been raised by Annas (1987); Kolder, Gallagher, Parsons (1987) in non-HIV concerns. Social workers find cases involving women to be much more problematic, due to the lack of family services, and the need for case management to the children's needs.

Gutuerrz (1990) calls attention to the fact that

women of color constitute a large proportion of social workers clients. Yet the unique needs of these women have rarely been presented in the social work literature. This researcher study purports to address this gap in social work literature by exploring a set of factors that contributes to Women At Risk For HIV/AIDS. Social workers must mobilize around those critical issues and problems challenging the profession in working this population.

Significance/Purpose of Study

There is a need to dispel misconception, misunderstanding and to discover the true sociological issues facing Women at Risk in HIV/AIDS. AIDS has emerged as one of the preeminent social and public health problem of our time. The significance of this study will be reflected in the overall objective, i.e., explore those factors and circumstances that account for Women At Risk In HIV/AIDS Crisis.

Certainly factors such as emotional isolation, alienation, stigma, and stress are crucial variables for social workers to address. Thus the purpose of this exploratory descriptive study is to identify, examine and address those selected variables that impact on the psychosocial functioning of this population. For social workers to plan and intervene appropriately with this population, it is appropriate to address specifically issues of self-esteem and attitudes. Attention will be given to the African American women, as she is disproportionately impacted by HIV/AIDS, Much of the literature will address the African American women experience with growing up Black in America, and constantly struck with those negative references associated with being Black. Hopefully,

social workers will remain mindful of the mechanisms of racism and sexism as they impact HIV-infected women.

CHAPTER TWO

LITERATURE REVIEW

Before we can come to grips with the Attitudes of Women At Risk for HIV/AIDS some general background information on the African American women is essential. To begin with Marshall (1979) provides this perspective, the history of the Black women is one of malicious abuse. She has been treated as a breeder by the white slave master have been hated by the white woman (the master's wife), and has been looked upon by Black men as a castrator. She has had to be strong; she has had to hold the family together. In far too many cases she has had to be bread winner, the financial thermostat, nurse and teacher of the young. She has been the one responsible for keeping her children's minds, soul, and bodies, intact. Faced with these tasks, the Black women had to be strong, with no reward offered for survival. Certainly, social workers must recognize those oppressive experiences associated with being Black together with America's idea of a woman's role has direct and concrete effects on the experiences of African American women diagnosed with HIV/AIDS.

Indeed, despite the overwhelming historical experiences of growing up Black and a women in America, the African American women with HIV/AIDS very survival is at stake. Like other women, African American women who discover an HIV infection often experience heightened anxiety, denial and preoccupation with maintaining her historical role as the giver of sustenance to the family and community. For the African American woman who has physical symptoms of HIV disease, additional concerns emerge: ...her role a primary care givers to a child or children or to other adults in the household is immediately affected. The family is severely disrupted, and she herself has to make many adjustments. Even if her children are healthy and uninfected, they may be indirectly affected by her diagnosis because of prejudices and fear. With AIDS her ability to care for her child, or community is impaired. Since most pediatric AIDS cases are the result of maternal transmission, the African American woman experience heightened guilt and anxiety, (Shaw, 1988). It is crucial that the social worker for the African American woman be intimately aware of this role conflict (nurture/perinatal transmission).

Additional issues in the treatment of the African

American Woman with HIV/AIDS are crucial, significant and controversial. According to Gutierrez, (1990) lack of access to many social resources is both a cause and an effect of the powerlessness of this population. Wilson (1987) suggest that the poverty rate of African American women is more than double that of white women: 32.3 percent of all African American Women are poor. Therefore, African American women are more likely than white women to suffer from poor or no housing insufficient food and clothing and inadequate access to health services, (Gordon-Bradshaw, 1987).

Trotman (1984) notes this view, women and Black are neither valued or noted in a white male-dominated culture. Even for women who are not poor, powerlessness contributes to poor mental health outcomes. Women, the poor and members of ethnic and racial minority groups have much higher rates of mental illness than do men, whites, and the more affluent (Pearlin & Schooler, 1978; Thoits, 1983). Growing up African American in this society, one is constantly struck with negative references associated with being Black and female.

Although women compose only 7 percent of all reported AIDS cases in the United States, they are an

important potential source for heterosexual HIV transmission as well as the source of transmission to infants (Shaw 1988). Guinan & Hardly, (1987) cautioned that when one looks at other characteristics of women with AIDS, one sees that AIDS, is not spread evenly among racial or social classes, as it is more or less among gay men. Over all, both male and female heterosexuals with AIDS in this country tend to be people of color, half Black and about one quart Hispanic. As one would expect, children with AIDS are young: AIDS affects women in their childbearing years, with one third of women with AIDS being 29 years old or younger and another 45 percent between the ages of 30 and 39, (Cochran, Mays, 1990). AIDS caught the social work profession off guard. AIDS affects stigmatized segment of society, making the politicalization of the syndrome more serious. Haney (1988) a social worker with AIDS, viewed many of the potential psychosocial consequences of AIDS as disconnections. AIDS disconnects people from the past, present, and future from loved ones, from their ways of defining themselves such as job, activities, capabilities, skills, and physical appearance, and perhaps most importantly, from a sense of power and control over their life, hopes,

dreams and aspirations.

Women of every age, ethnic backgrounds, class, and sexual orientation have contracted HIV, but HIV infection occurs with greatest frequency in the African American population, according to Cochran, Mays & Roberts (1988). At the present, 24 percent of reported AIDS cases have occurred among Blacks, although Blacks constitute only 12 percent of the United States population, among women affected, Blacks account for 52 percent. Blacks are at greater risk for getting AIDS, while this is true, it is relevant to note that particular members within the African American community are more at risk than others. As of 1987, the presumed primary routes of infection was IV drug use. Many of the heterosexual transmission cases are from sexual contact with IV drug users Deslarlais et. al., (1987).

For African American Women, AIDS is a disease strongly associated with sociological realities of poverty. The poor, urban ethnic minority communities, IV drug use is much more common, as is the sharing of needles or "works" (drug paraphernalia) the primary route for HIV transmission (Friedman, et al., 1986). In addition simply living in this environment is more

likely to result in contact with HIV infected individuals who may be potential sexual partners.

Taylor & Adams (1986) notes other factors in poor ethnic minority environments that may also contribute to the spread of HIV. For example, Black culture seen to have a disdain for the use of condoms as a method of birth control. While condoms may effectively fight the HIV virus, they are primarily associated with birthcontrol. In some African Americans birth control is viewed as genocidal, depriving individuals as well as the communities of the ethnic pride associated with parenthood. Social workers need to recognize that current risk reduction messages encourage condom use without consideration of their economic burden. To suggest that African American Women living on a meager fixed income spend money on condoms, particularly when her partner is perhaps reluctant to use them, ignores the economic and social pressures in her life.

Social workers need to be aware of some special psychosocial concerns that arise in the care of the African American woman with HIV/AIDS. There is evidence according to Cochran and Mays (1988) that cultural, ethnic, and racial barriers may create difficulties in communication that undermined the

social worker-client relationship. Cultural and ethnic barriers can compromise obtaining necessary information from client as well as assurance that they understand risk reduction activities. For example, social workers have been encourage by ethnic community AIDS workers to refer to condoms as "rubbers" or "protection". These language distinctions are important.

Other issues may be even more subtle. For example, among African Americans a cultural norm is that one should behave more formally in the presence of non-Blacks to avoid the discriminations that occurs unpredictably as a result of racist notions that Blacks are ignorant or poorly mannered. Culturally, African Americans particularly from the lower socioeconomic groups, are expected to avoid those moments of vulnerability as a protection against possible discrimination, Mays and Cochran, (1987).

Limited information has been published addressing the specific psychological needs of African American women with HIV/AIDS. African American Women affected with HIV/AIDS differ from whites in their family and friendship, networks and in the ethnic and cultural norms that play in their health care behaviors. For example, according to Mays and Cochran (1987),

homosexuality is viewed differently in ethnic minority cultures. The gay ethnic minority man with AIDS may have chosen never to reveal or discuss his sexual orientations with his friends or family. In many instances such behaviors has been well hidden by occasional heterosexual liaisons or is a known "secret" not talked about by his family or friendship network. It is important that social workers respect the role of this family secret in maintaining sources of social support. Homosexuality and bisexuality exist in the African American community, but it is expressed, understood, and viewed differently by the community, Dalton (1989).

An important issue for social workers to be aware of is the reaction of women at risk. Women who suspect that they contracted AIDS through sexual contact with a gay or bisexual man have specific issues to explore according to Buckingham & Rehm (1987). The issue of disclosure is a critical concept in understanding of the African American women.

Most individuals apply mixed strategies over time to cope with the threat of HIV infection. An example would be the woman who insist upon a condom at first, but suspends condom use once interpersonal trust in

established with her new partner. She establishes this trust by getting tested for HIV antibody with her partner, gaining assurances of monogamy from him, or from simple reassurances from him, which in some cases may not be honest. Cochran & Mays, (1990), in one sample of college students, 20 percent of the males said they would lie about their HIV antibody status in order to have sex with a women. Certainly, social workers must assist the woman throughout the "courtship" to obtain accurate information about one's own and one's partners antibody status, to develop and refine negotiating skills for use in discussing sexual matters, and to decide upon sexual practices that actually protects against HIV infection.

The reduction of risk depends greatly upon the level of knowledge among African American women at risk. Since HIV first appeared in the United States, social work professionals have waged a war of education against misinformation and ignorance about the disease. Most educational efforts have focused on the symptoms of the disease, how the virus is spread, and what preventive actions are effective to guard against infection.

Among risk factors in the United States, only

homosexual contact has been associated with more cases of AIDS than intravenous drug use (Center for Disease Control, 1990). Since IVDU serve as a major conduit of the HIV to non drug-using African American women sex partners and their children, education and prevention efforts aimed at reducing high-risk behavior in this population continue to be of utmost importance for social work practitioners. According to, (Becher, 1988; Friedman, DesJarlais, & Sotheran, 1986) education efforts targeting IVDUs face several obstacles, including functional illiteracy, a commitment to a deviant subculture, and suspicion among drug users of "square" society and its emissaries. As a result, it is important for social workers to determine the efficacy of various educational strategies aimed at this population.

The Center for Disease Control (1989) in a survey interview on Health Statistics, indicates a trend of increasing knowledge concerning AIDS in the general United States population, especially regarding the transmission of the disease. Knowledge of AIDS has been assessed in Several different populations, including adolescents (Strunin, Hignson, 1987; Zimet, et al., 1989; D. Clemente, Boyers, & Morales, 1988;

Goodman & Cohall, 1989; Huszte, Clopton & Mason 1989) college students (Rhodes & Wolitski, 1989; Gilliam & Seltzer, 1989), teachers (Wilson, Sibanda, Greenspan & Wilson, 1989), Blacks and Hispanic adults (Santini, Washington & Smith, 1989) dentist (Gerbert et al., 1988), state employees (Nyamathi & Flaskerud, 1989), clients from sexually transmitted disease clinics (Beaman & Strader, 1989), and IVDUs (Selwyn, et al., 1989 Friedman, DesJarlais, and Sotheran, 1986; Ginzburg, et al., 1986). Most of these studies levels of knowledge of AIDS based on measures taken at one point in time. Almost all of the studies cited above show that in virtually every group studies, large gaps exist in knowledge concerning AIDS. For instance, in their study of knowledge among, adolescents, DeClemente, et al., (1988) found that most do not know that the cause of AIDS has been identified, about half believed the AIDS can be cured if properly treated, and nearly half do not believe that using condoms reduces the risk of getting AIDS.

Studies of IVDUs generally show them to be knowledgeable about the risk of infection associated with sharing works (needles and syringes), other gaps in their knowledge about AIDS exist. Data from

(Ginzburg, et al. 1986) showed that nearly half of the IVDUs surveyed did not understand the risk of prenatal infection, and more than a third of the IVDUs interviewed believed that HIV-infected persons usually look sick.

A decade into the epidemic, information about AIDS is now well established in the public mind. Most individuals are aware of the disease and shaped some rationale to guide their behavior and avoid HIV infection. However, successful strategies for avoiding the transmission of HIV may vary from one population to another, contingent upon the existence and nature of community norms regarding sexuality, (McKusick, et al., 1985).

Since the early stages of the epidemic, there has been controversy about how to advocate safer sex in health education campaigns for heterosexuals: it is better to target sexual behavior, promote condom use, or to recommend abstinence and monogamy? Less concern about AIDS among heterosexual control of unsafe sex to avoid HIV transmission (Guydish, Coates, & Ekshand, 1990; Stall, Heurtin-Roberts, McKusick, Haff & Lang, 1990). However, opinion varies whether to encourage heterosexuals to adopt strict safe sex practices based

on epidemiological predictions of potential penetration of HIV through heterosexual relations.

Fumento (1990) estimated the chance of HIV infection to a woman living in a metropolitan area who has unprotected vaginal intercourse with 10 different partners at 1:16,000. Hearst and Hulley (1988) estimated risk for "low-risk: persons (unknown serostatus who engage in vaginal intercourse using condoms) as 1:110,000. Among heterosexuals, there is a slight chance of becoming infected, even less if one is careful about selecting one's partner. This is the view taken by Fumento, and his associates, conversely, the fact that there is a possibility of new infections at all in this population is a matter of public health concern. This view is espoused by health educators who advocate strict safer sex guidelines for all sexually active adults, heterosexual or homosexual, who are not in a long term monogamous relationship (Koop, 1988; Horsburgh, Douglas, & LaForce, 1987; Goldsmith, 1987).

Blaumstein and Schwartz (1983) reported from their sample that traditional heterosexual marriages tend to be more sexually exclusive, for two primary reasons: (a) Historically, women are homemakers with limited opportunity to develop relationships outside the

marriage and (b) sexual exclusivity is a moral ideal. Nonexclusivity crosses over both religious and legal barriers. Heterosexual cohabiting couples, although less conforming than married couples, are more influenced by traditional heterosexual roles than gay couples.

Robin and Ickovics (1988) suggest that women are at greater risk than men for acquiring AIDS through heterosexual intercourse. Although anal intercourse has been associated with heterosexual transmission of the AIDS related viruses, other studies have suggested that vaginal intercourse alone is sufficient for viral transmission (Fischl et al., 1987; Redfield et al., 1987; Stewardt et al., 1985). Campbell (1988) suggest that the high rate of heterosexual transmission of HIV for women underscores the need for sexually active women to be aware of the risk they face from partners who they do not know well. The high rate of transmission from undetermined risks tend to suggest that women may not know about past IV drug use or bisexual practices of their partners.

Sparks (1987) suggest that with women who test positive for HIV antibodies, women diagnosed with AIDS or ARC do not understand the meaning of the diagnosis.

It appears that women do not go for medical treatment until they begin to experience symptoms and usually in an advanced stage by the time it is diagnosed. For women, the survival time from a AIDS diagnoses to death is half that of men.

There is speculation that AIDS is a different disease in women that in men. Kolata (1987) cited studies in New York, Florida, and California that women tend to become more severely ill and die quicker than men after diagnosis. Kolata postulates that one possible reason for the significant gender difference is that doctors typically do not perceive HIV disease as a diagnostic option unless a woman is a prostitute or an intravenous drug user. It is possible that gynecological diseases, such as chronic vaginitis, yeast infections, and pelvic inflammatory disease remains not acknowledged as potential symptoms of HIV disease. Cohen (1990) suggest that a life threatening illness such as AIDS has a profound psychological impact on the patients. A person may face separation from family, friends, loss of key roles, permanent changes in appearance in bodily functions, assault on self-image, self-esteem, guilt, anger or helplessness. Stulberg and Buckingham, (1988) note that the

psychosocial issues faced by women diagnosed with AIDS include fear of rejection, social isolation, shame, denial, radically altered roles, destruction of their expectation, hopes and dreams for the future and emotional devastation caused by AIDS.

Newly diagnosed individuals tend to curtail their sexual behavior, Shilts (1987) and isolate themselves from friends, family and partners (Altman, 1987; Korniewicz, O'Brian and Larson, 1990). Krieger (1988) suggest that guilt feelings are a major component of this severe anxiety. According to Ross (1989) the attitudes this behavior provokes decreased ability to achieve intimacy, sexual guilt, denial of risk, depression characterized by self pity and hopelessness self destructive behavior and distance from social support. For those experiencing the disease a vast range of psychosocial symptoms have been reported, including depression, guilt, suicidal, ideation, anger, powerlessness and alienation (Eustace, 1988; Govini, 1988; Rubinow, 1984; Korniewicz, et al., 1990).

Goffman's theory (1963) describes the concept of stigma in relation to one's ability to socially interact within a group. Stigma refers to a deeply discrediting attribute that affects the relationship of

individuals within society. Attitudes towards stigmatized individuals reflects both the individuals' perceptions of self and others perceptions of the individual. Stigma implies that an individual has been categorized as "different" from others and therefore outside society.

Lauer-Listhaus (1988) states that clinical observation of HIV infected patients indicates that they frequently view themselves as different than other patients with chronic disease. Psychosocial changes are evidence by stigmatized individuals including alteration in self-concept, self-esteem, social alienation and social functioning, Goffman, (1963). He describes these concepts in terms of social roles and the ability to be socially accepted. Decreased self-concept is defined as the perception of self that are different and not socially accepted.

Kelly, Hood & Smith (1990) observed that health care professionals who intervene with AIDS patients have observed that such irrational avoidance and fear frequently contributes to isolation and social stress which adversely affect the ability to cope with the illness. Cohen (1986) shares this view, that people with AIDS are overwhelmed with severe and multiple

illness, decreased cognitive functioning, devastating weakness, weight loss, fevers, cancers, opportunistic infections, disfigurement, blindness, pain and psychiatric disorders. Women often feel pressured to acquiesce to their partners demands for unsafe sex fearing angry or violent responses, rejection or abandonment (Macks, 1988; Shernoff, Palacious-Jimenz, 1988). Women trapped in violent manipulation or coercive relationships can not protect themselves. Battered women are at an especially high risk of infection because of their lack of self-esteem and ability to negotiate with their partners, Gibson (1991).

Sparks (1987) in her study found that many women put others needs above their own in ways that make it difficult to insure safety for themselves in sexual encounters. AIDS has impacted negatively on women's sexual lives and has generated new issues and produce stress for women. She found in her study that women in very traditional roles often feel embarrassed to discuss their sexual activity or to ask their partners to protect them by using a condom.

Moynihan and Christ, (1988) note that friends or relatives of persons with AIDS may feel that the person

brought the disease on herself that the future of the family is being threatened and that they too will experience prejudice and alienation.

Shernoff and Bloom (1991) observes that the awful shadow of AIDS is cast dark and wide. We have been learning to live and to love in its somber light. This research is an example of this researcher attempt to identify interventions in social work that will help foster the desired behaviors and attitude changes necessary to survive and thrive in the age of AIDS.

Theoretical Orientation

The ecological perspective will provide the theoretical framework for this study. Germain and Gitterman, in Turner's work (1986) suggest the ecology concerns itself with the relation between living organism, in this case human beings and all elements of the environment. It examines how human beings achieve a goodness-of-fit or adaptive balance and how and why sometime fail to do so.

Women who are diagnosed with HIV/AIDS desire a goodness-of-fit with their environment and surrounding. They seek sense of relatedness and a connectedness to their environment to give support when confronted with this devastating disease. The ecological perspective

support the idea that all living forms need to receive from the environment the stimuli and resources necessary for development and survival. The lack of human basic needs generated life stress. The external demands that are placed on women as caretakers, sexual partners, mothers and co-partners, and the internal stress placed on themselves upset a normal routine of life. These demand bring about an imbalance of stressful circumstances for the diagnosed HIV/AIDS women to cope and try to adapt.

Life stress is associated with negative feelings of low self-esteem, anxiety, guilt, anger, and despair, Germain & Gitterman (1986). Women attempt to cope with these emotions while coping with their diagnosis and other responsibilities and the environment gives them little support. Coping efforts are the special adaptation extorted by the experience of stress. These women are trying to cope under relatively difficult circumstances and conditions that accomplish the HIV/AIDS diagnosis and few elements for support from the environment.

The ecological perspective support the idea that life transition impose new demands and require new responses as changes that are brought about by a

crisis. All life transition requires changes in the life self-image, ways of looking at the world, the processing of information derive from cognition, perception and feeling patterns of relating to other users of environmental resources, and goals requiring the restructuring of one's life space.

The women who are diagnosed HIV/AIDS are having new demands imposed upon them by the mere fact of the diagnosis and the implication that it carries. One's self esteem is effected in relation of one being able to identify the source of transmission, through drug use or sexual contact. Women experience the feeling of stigma, stress and feel guilt, isolation and may feel and precedes others in the environment reacting to them different once the diagnosis has been identified. The causation impacts on women and demand that they restructure their own normal life pattern.

Definition of Terms

Stress - any influence that interferes with the normal functioning of an organism and produces some internal strain or tension. "Human psychological stress" refers to environmental demands or internal conflicts that produce anxiety. People tend to seek an escape from the sources of these influences called stressors

through such means as defense mechanisms avoidance of certain situation. Baker, R. L. (1989).

Self Esteem - an individual's sense of personal worth that is derived more from inner thoughts and values than from praises and recognition from others. (Gould, & Kolk (1964).

Attitude - an attitude is the individual's organization of psychological processes, as inferred from his behavior, with respect to some aspect of the world which he distinguishes from other aspects. (Gould, J., Kolk, L.W (1964).

Acquired Immune Deficiency Syndrome (AIDS) - is an infectious disease caused by a virus called Human Immunodeficiency Virus (HIV). It is a fatal disease which causes the failure of the human immune system and leave the body unable to fight infection. (Evans, Beauchamp, Dayton, Neuman, Osborn, Rosenbaun, and Van Hass, 1988).

Human Immunodeficiency Virus (HIV) - the Causative Agent of AIDS (Daniel, 1987).

Shernoff, (1988) discusses is his work and defines level of risk of sexual behaviors as follows.

No Risk - activities involving no exchange of blood, semen, vaginal secretions, urine, or feces pose no risk

of a consenting partner, including flirting, fantasy, solo masturbation, hugging, body rubbing, dry kissing, massage, showering together, mutual masturbation with external (on me, not in me) orgasms, light sado-masochism without bleeding or bruising, phone sex, talking "dirty", watching another person, being watched.

Probably Safe - barrier-protected activities are safe as long as the barrier remain in tact in place, and is used properly. These activities include anal or vaginal intercourse with a condom and a water-based lubricant using a spermicide for vaginal intercourse and/or withdrawing the penis before ejaculation; fellatio with no exchange of semen (a condom can be used and/or ejaculation can take place outside the mouth); cunnilingus or anilingus (rimming) with a latex sheet (dental dam) or plastic wrap over the vulva or anus; covering shared sex toys with an unused condom or latex barrier; branchioprocitic/brachiovaginal sex (fisting) with a latex glove.

Possibly Risky - activities during which exchange of body fluids might create some danger of transmitting HIV, but from which no known cases of transmission have occurred to date, including deep kissing, particularly

if there are cuts or sores where blood might be present in the mouth; oral, anal, or vaginal intercourse without a condom and withdrawing prior to ejaculation; cunnilingus with a menstruating women; sharing sex toys or enema equipment that have come in contact with vaginal secretions, semen, or blood; fisting if the hand has cuts or sores on it (the risk is increased if internal tears are produced and there is subsequent intercourse); mucous membrane or broken skin contact with urine or feces; rimming.

Risky - fellatio with ejaculation in the mouth has been linked to HIV transmission for the receptive partner in some cases.

High Risk - anal and vaginal intercourse without a condom and with internal ejaculation are dangerous for both partners, but put the receptive partner at greatest risk.

Statement of the Hypotheses

This study focuses on the attitudes and self-esteem of diagnosed and non-diagnosed Women at Risk for HIV/AIDS. To fully understand their relatedness, the study addresses the following questions:

1. Does the HIV/AIDS diagnosis show a relationship to the attitudes of Women at Risk.
2. Does the HIV/AIDS diagnosis show a relationship to self esteem of Women at Risk.

Hypothesis #1 There is no significant difference between the attitudes of diagnosed and non-diagnosed Women at Risk for HIV/AIDS.

Hypothesis #2 There is no significant difference between self-esteem of diagnosed and non-diagnosed Women at Risk for HIV/AIDS.

CHAPTER THREE

METHODOLOGY

Research Design

A comparative research design was used to compare the diagnosed and the non-diagnosed women. The comparison was made on the following variable: attitudes and self esteem.

Sampling

The non-probability convenience sample was used. This sample consisted of those individuals who were convenient to the research and were willing to respond to the researcher's questionnaire. The sampling population was drawn from the Infection Disease Clinic at Grady Hospital located in Metropolitan Atlanta, Georgia. The I.D.C. was chosen because of the availability of a diagnosed population of Women at Risk for HIV/AIDS and are attending the clinic for weekly medical service. The non-diagnosed Women at Risk for HIV/AIDS were drawn from a group of women employed at the Jackson Community Mental Health and Day Treatment Program in Jackson, Tennessee. This population was chosen because of the low incidence of women diagnosed with HIV/AIDS.

Variables used to select this sampling population included confirmed diagnosed status of women with HIV/AIDS. A total of twenty-five women initially interviewed met the criteria; however, only twenty-two agreed to participate in the sample group.

A total of twenty-two females diagnosed and twenty-four females non-diagnosed, 32 subjects were between the ages of nineteen to thirty six, and 15 over the age of 36 experiencing a range of social and psychosocial concerns about the HIV/AIDS epidemic.

Data Collection Procedure

(Instrumentation)

The instrument that will provide the necessary data for this research project is a 56-items self reporting questionnaire adapted Illness Behavior Questionnaire (IBQ) Pilowsky and Spence, (1983). Information from this questionnaire was used to measure the respondent's attitudes, in relations to the illness of women at risk for HIV/AIDS. Additional question were adapted from the Fitts Self-Concept Scale. This scale measured how diagnosed and non-diagnosed women felt about themselves. (See Appendix A).

The questionnaire, in its entirety, consisted of 56 items: 7 questions on demographics, 25 questions on

attitudes about sexually, sexual behavior, family support, and twenty-five of self-esteem. These test have been used several times in the past and have proven to be highly reliable and valid.

Confidentiality and anonymity was insured. From the sample, the diagnosed and non-diagnosed women at risk were given the option to refuse to participate in the study. Clear instructions for completing the questionnaire were provided. Time was allocated for questions and answers, the questionnaire took approximately thirty minutes to complete. Expressions of thanks was given to all subjects. The questionnaire was collected from the participants the day of completion.

As a result of this process, there were few deletions. The women did not express any anxiety about sharing this type of information; therefore, there were no alterations in the approach.

Data Analysis

The collected data was coded and analyzed using Clark Atlanta University, SPSSX Computer. The descriptive statistics was used to analyze the data including frequency distribution, percentages and T-Test.

CHAPTER FOUR

PRESENTATION OF RESULTS

Before delving into the characterization of the findings of this study, the researcher used the following hypotheses:

Hypotheses #1 There is no significant difference in the self-esteem of diagnosed and non-diagnosed women at risk for HIV/AIDS.

Hypotheses #2 There is no significant differences in the attitudes of diagnosed non-diagnosed Women at risk for HIV/AIDS.

According to the statistical analysis from the study, the researcher administered questionnaires regarding the attitudes and self-esteem of the women at risk for HIV/AIDS, 46 of those questionnaires were returned to the researcher. Out of the forty-six respondents that participated, thirty-one were between the ages of nineteen years, and thirty-five, fifteen were over the age of thirty-six years. The T-Test was used to determine if there was any significant differences.

The finding showed that there was a significant difference in hypotheses #1 (+6.64, df=43, prob. .000).

The null hypotheses was rejected. The findings showed that there was a significant differences in hypotheses #2 (+4.58, df=43, prob. .000). The null hypotheses was rejected.

Table 1 Sampling Group

This section consisted of the women who participated in the sampling, this is illustrated in the chart.

	F	P
Infection Disease Clinic	22	42.8
Jackson Counseling Center	24	52.2

F=Frequency

P=Percent

The sampling unit consist of 22 (47.8) clients from the IDC Clinic of Grady Hospital in Atlanta Georgia, and 24 (52.2) staff member of the Jackson Counseling Center, Jackson, Tennessee.

Table 2 Age

The demographic data consist of the following variable: age, marital status, income, employment status, number of children, level of education and HIV status. The chart illustrates the age of the women who were in the sampling:

	F	P
UNDER 20	1	2.2
21-25	8	17.4
26-30	14	30.4
31-35	8	17.4
OVER 36	15	32.6

F=Frequency

P=Percent

This section consist of the age range of the women: one was 20 (2.2) or under, 8 (17.4) were in the age range of 21-25, 14 (30.4) were found to be in the range of 26-30, 8 (17.4) were in the range of 31-35, and 15 (32.6) were over the age of 36.

Table 3 HIV Status

This section consist of the status of women who has been diagnosed and non-diagnosed for HIV/AIDS. The chart illustrated this.

	F	P
HIV+No Symptoms	6	27.3
HIV+Some Symptoms	13	59.1
AIDS Diagnosed	3	13.6
Non-Diagnosed	24	100.0

F=Frequency

P=Percent

This section consist of the women who were diagnosed with HIV/AIDS infection. 6 (27.3) were diagnosed with HIV and were asymptomatic, 13 (59.1) were diagnosed with HIV and experiencing some symptoms of the virus. This was the majority of who made up the HIV positive status population. There were 3 (13.6) diagnosed with AIDS, and 24 (100.0) non-diagnosed.

Table 4 Marital Status

This section illustrates the marital status of the women who were respondents. This chart illustrates this:

	F	P
Single	16	34.8
Married	16	34.8
Divorced	6	13.0
Separated	7	15.2
Widowed	1	2.2

F=Frequency

P=Percent

There were 16 (34.8) respondents single, 16 (34.8) were married. The single and married groups made up the majority of the sample, 6 (13.0) were divorced, 7 (15.2) were separated and one widowed (2.2).

Table 5 Relationship With Family and Friends

This section illustrates how the respondents, responded to the questions. Illness affect your relationship with family and friends.

	F	P
Diagnosed		
Yes	13	59.1
No	9	40.9
Non-Diagnosed		
Yes	0	0
No	24	100.0

F=Frequency

P=Percent

This sections illustrate that 13 (59.1) of diagnosed women experience problems with family and friends, 9 (40.9) that does not and none of the non-diagnosed women had any difficulty with family or friends.

Table 6 Feeling Attractive

This section describes how the respondents responded.

<u>I am an attractive person</u>	<u>F</u>	<u>P</u>
Diagnosed Group		
Completely False	2	9.1
Mostly False	12	54.5
Mostly True	7	31.8
Completely True	1	4.5
Non-Diagnosed		
Completely False	2	4.3
Mostly False	15	32.6
Mostly True	18	39.1
Completely True	11	23.9

F=Frequency

P=Percent

The Chart illustrates that 2 (9.1) of diagnosed women believed the statement was completely false, 12 (54.5) believed it to be mostly false, 7 (31.8) believed it to be partly true and 1 (4.5) believed it to be mostly true.

In the non-diagnosed group 2 (4.3) believed it to be completely false, 15 (32.6) believed it to be mostly

false, 18 (39.1) believed it to be partly true and 11 (23.9) mostly true.

Table 7

Hypothesis #1: There is no significant difference between the attitudes of HIV/AIDS diagnosed and non-diagnosed women. The chart illustrate the finding:

<u>Attitude</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>T-Value</u>
Diagnosed	43.2	2.467	6.64
Non-Diagnosed	36.1	4.415	

P..000

Based on the results of the T-table seen in table 7 (+6.64, df=43, prob. 000) There is a significant different between the attitudes of diagnosed and non-diagnosed women. The research hypothesis was rejected.

Table 8 T-Test

Hypothesis #2: There is no significant difference between self-esteem of HIV/AIDS diagnosed and non-diagnosed women. The chart illustrates the finding:

<u>Self Esteem</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>T-Value</u>
Diagnosed Group	101.3	4.50	4.5
Non-Diagnosed	95.3	4.645	

P.. 000

Based on the result of the T-table seen in table 8 (+4.58, dF 43, prob 000.) There is a significant different between the self esteem of diagnosed and non-diagnosed women. The researcher hypothesis was rejected.

CHAPTER FIVE

SUMMARY AND CONCLUSION

As a result of the research findings the research rejected the null hypothesis that there is a statistical significant difference between the diagnosed and non-diagnosed women of attitudes and self esteem.

Based on the result of the findings in this study it can be concluded that there is a clear need to continue to educate women about HIV/AIDS. The findings indicate that the HIV/AIDS diagnosis has a profound impact on the attitudes and self esteem of women.

The majority of the diagnosed women (59.1) experience difficulties with family and friends. Cohen (1990) support the findings in his works when he suggest that a person with life threatening illness such as AIDS has a profound psychological impacted on the patient. A person may face separation from family and friends... an assault on self image and self esteem.

Germain and Gitterman in Turners' work (1986) support the thought that all living organism need stimuli from the environment in order to have a

goodness-of-fit. This applies to diagnosed women, the finding indicates without the stimuli from the environment, the attitudes and self esteem is profoundly impacted. The findings indicates that women at risk need the support and stimuli from the environment to help to cope and adapt to the best of their ability.

Limitation

A major limitation of this study was the small sample size. Only a total of forty-six women were surveyed and this decreased the representation of this population of Diagnosed Women at Risk for HIV/AIDS. As a result the outcome of the research cannot be generalized to the total population of Women At Risk.

Another limitation was that all of the diagnosed respondents all came from one health care provider, and cannot be generalized to all Women At Risk.

Suggested Research Direction

This research recommend that a more comprehensive instrument could have been formulated to include and address more in dept questions of how the diagnosis affected the overall level of functioning on the psychosocial aspect of the diagnosed women at risk. A larger sampling population of HIV/AIDS diagnosed and

non-diagnosed women would allow a better representation of a population of each group, as a result, the findings could be generalized to a larger population.

It may be very beneficial to seek respondents from other HIV/AIDS providers to get another segment of this population. Further research should be done to give social workers and other HIV/AIDS services providers an understanding of the impact of HIV/AIDS virus has on the attitudes and self-esteem on women.

CHAPTER SIX

IMPLICATION FOR SOCIAL WORK PRACTICE

This study suggest that knowledge, theory and practice are the most promising tools yet available in the control of HIV/AIDS infection among Social Workers intervening on behalf of women at risk for HIV/AIDS, specifically African American Women.

There currently are not enough knowledgeable or trained social work practitioners to provide essential services to women at risk for HIV/AIDS, specifically African American women. Ryan (1991) notes that the profession is especially in short supply of minority, bilingual and bicultural, and AIDS social workers.

Social workers, with their special knowledge, skills, and sensitivity, are uniquely capable of responding to the AIDS crisis. Social worker may draw from a body of knowledge developed by social work practitioners in working with cancer terminally ill persons. However, there is a need for social workers according to Ryan and Rowe (1988) to understand the complex legal, ethical, value issues surrounding AIDS care and intervention are also key topics for developing social work practitioners. Granted social

workers adequately prepare to deal with death and dying issues and anticipatory grief. Research knowledge is needed to improve the social work fields of understanding of the role of psychosocial factors in predicting family members willingness to care for people with AIDS. The scarcity of empirical research literature on Women At Risk for HIV/AIDS-African American women is due in part to racism, sexism and difficulty of conceptualizing a model for professional intervention with this population and due in part to a reluctance of social workers to overcome their stigmatizing attitudes towards this population. Viewed from another perspective, African American women with HIV/AIDS challenges social workers to change themselves by dealing with feelings of pain, racism, sexism, illness, death, and the illusion of personal immortality.

Social workers must receive skilled supervision, periodic retraining; formulate educational programs with psychosocial content; develop services for those at risk, their significant others, and service providers, and engage in program planning on a community level in African American communities.

The eco-system theory (model) informed this

research study. For professional intervention with this population, few resources are required to apply eco-systems theory. Significant practice skills and knowledge can be acquired if the social worker is willing to work with the women affected by this devastating disease autonomously, that is, in the roles of advocate, mediator, teacher, consultant, counselor, therapist, and a willingness to experience failure. Social workers, with their special knowledge skills, and sensitivity, are unequally capable of effective practice with this population, if they are willing to invest in three areas: self-awareness, current knowledge, and mobilization of resource.

Every social worker has the opportunity to help change a small portion of events by not shunning away from women at risk for HIV/AIDS particularly African American women; but to be challenged and provide the most effective and efficient services possible.

Certainly further research and refinement of practice skills are essential. For this to occur, social work must develop a frame from reconceptualizing practice directed at servicing African American women.

Research is also required to further determine the needs of this population who may reject and be rejected

by traditional health care arrangements for service. More sophisticated research tools must be developed before further effective study can occur. Specifically, professionals in the field for a variety of reasons tend to ignore data that do not fit in the pejorative mold of scholarly research. Such myopic views prevent the development of a conceptual framework that would permit understanding of the life experiences of women at risk for HIV/AIDS.

It is important to create this framework, social workers must recognize that such life experiences have value both as a basis for practice and as an acceptable base for future research.

This researcher hopes that some of the mysteries, fears, and misconceptions held about African American women at risk for HIV/AIDS will inform social work profession and reduce the negative impact on this population.

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APPENDICES



March 21, 1991

Dear Participant,

I am Mary Thomas, a graduate Social Work Student at Clark Atlanta University. I am conducting a research study designed to assess the Self Esteem And Attitudes Of Women Diagnosed With The HIV Infection. Please assist me by completing the attached questionnaire. This should take approximately 15 minutes. Your participation is strictly voluntary.

Do not place your name on the questionnaire. Your responses will be completely anonymous. I would like for you to answer each question as carefully and as accurately as possible.

Thank you for your cooperation.

Sincerely,

Mary Thomas

Mary Thomas,

Master Social Work Student

Hattie Mitchell

Professor Hattie Mitchell,

Thesis Supervisor

ATTITUDE ASSESSMENT QUESTIONNAIRE

PLEASE CHECK THE ANSWERS THAT ARE MOST APPROPRIATE TO
YOUR SITUATION.

Demographics;

- | | | |
|-----------------------------------|--|------------------------------------|
| 1. AGE | 2. INCOME | 3. MARITAL STATUS |
| <input type="checkbox"/> UNDER 20 | <input type="checkbox"/> UNDER 9,999 | <input type="checkbox"/> SINGLE |
| <input type="checkbox"/> 21-25 | <input type="checkbox"/> 10,000-14,999 | <input type="checkbox"/> MARRIED |
| <input type="checkbox"/> 26-30 | <input type="checkbox"/> 15,000-19,999 | <input type="checkbox"/> DIVORCED |
| <input type="checkbox"/> 31-35 | <input type="checkbox"/> 20,000-25,999 | <input type="checkbox"/> SEPARATED |
| <input type="checkbox"/> OVER 36 | <input type="checkbox"/> OVER 26,000 | <input type="checkbox"/> WIDOWED |

- | | |
|--|---------------------------------|
| 4. EMPLOYMENT STATUS | 5. NUMBER OF CHILDREN |
| <input type="checkbox"/> EMPLOYED | <input type="checkbox"/> 1-2 |
| <input type="checkbox"/> SELF EMPLOYED | <input type="checkbox"/> 3-5 |
| <input type="checkbox"/> DISABLE | <input type="checkbox"/> OVER 5 |
| <input type="checkbox"/> UNEMPLOYED | |

- | | |
|---|--|
| 6. PRESENT HIV STATUS | 7. HIGHEST LEVEL OF EDUCATION |
| <input type="checkbox"/> HIV+/NO SYMPTOMS | ACHIEVED: |
| <input type="checkbox"/> HIV+/SOME SYMPTOMS | <input type="checkbox"/> HIGH SCHOOL/GED OR LESS |
| <input type="checkbox"/> AIDS DIAGNOSES | <input type="checkbox"/> SOME COLLEGE |
| <input type="checkbox"/> NON-DIAGNOSED | <input type="checkbox"/> BACHELOR DEGREE |
| | <input type="checkbox"/> OTHER |

PLEASE ANSWER EACH QUESTION BY CIRCLING YES OR NO TO
EACH ITEM:

ATTITUDES:

- | | | | |
|-----|----|----|--|
| YES | NO | 1. | Does your illness interfere with your
life a great deal? |
| YES | NO | 2. | Do you ever find that you are often aware
of various things happening in your body? |
| YES | NO | 3. | Do you ever think of your illness as a
punishment for something you have done in
the past? |
| YES | NO | 4. | Do you think that other people realize
that you are ill? |
| YES | NO | 5. | Does it upset you to talk to your Social
Worker about your illness? |
| YES | NO | 6. | Does your illness affect the way you get
along with your family or friends a great
deal? |
| YES | NO | 7. | Do you know anybody who has the same
illness as you? |
| YES | NO | 8. | Are you afraid of your illness? |
| YES | NO | 9. | Can you express your personal feelings
easily to other people? |

- YES NO 10. Are you upset by the appearance of your face or your body?
- YES NO 11. Are you upset by the way people take your illness?
- YES NO 12. Do you find that you are bothered by many different symptoms?
- YES NO 13. Is it uncomfortable for you to talk about AIDS to your sex partner?
- YES NO 14. Do you question your new sex partners about their sexual history?
- YES NO 15. Do you question your new sex partners about their drug use?
- YES NO 16. Are you having less sex than you would like to because of AIDS?
- YES NO 17. Are you maintaining a monogamous relationship?
- YES NO 18. In the last 2 years have you had sexual relationship with someone you thought might be infected with the AIDS virus?
- YES NO 19. When you have sexual intercourse with someone do you provide the condom?

YES NO 20. In the last 2 years have you engaged in
anonymous sex with someone you met at a
public place?

YES NO 21. In the last 2 years have you had sex with
someone you knew used IV drugs?

YES NO 22. Do you use street drugs of any kind?

YES NO 23. Were you aware of HIV before you were
diagnosed?

YES NO 24. How many people did you have sexual
contact with in the last two years?

1-3__ 4-7__ 8-10__ 11-15__ MORE THAN 15__

PLEASE ANSWER EACH ITEM AS CAREFULLY AND AS ACCURATELY
AS YOU CAN BY PLACING A NUMBER BESIDE EACH ONE AS
FOLLOWS.

1. = Completely False
2. = Mostly False
3. = Partly True
4. = Mostly True

Self Esteem:

- __1. I am a bad person.
- __2. I have a family that would always help me in any
kind of trouble.
- __3. I am a religious person.
- __4. I am a morally weak person.
- __5. I am satisfied with my family relationships.
- __6. I am a member of a happy family.
- __7. I have a lot of self control.
- __8. I am satisfied with my moral behavior.
- __9. I despise myself.
- __10. I am an important person to my friends and
family.
- __11. I am an attractive person.
- __12. I am a decent sort of person.

- _13. I am a honest person.
- _14. I am a friendly person.
- _15. I get angry sometimes.
- _16. I try to run away from my problems.
- _17. I am a hateful person.
- _18. I am mad at the whole world.
- _19. I am popular with men.
- _20. I ought to go to church more.
- _21. I like my looks just the way they are.
- _22. I should love my family more.
- _23. I am not the person I would like to be.
- _24. I do not forgive others easily.
- _25. I get along well with other people.